National Rural Health Association Position Paper

Mental Health In Rural America

Policy Solutions

Rural America suffers from the effects of long-standing rural shortages of specialty mental health services, long travel distances to obtain treatment, and stigma and cultural/societal attitudes about efforts to ensure access to the full range of mental health services.[i]

Policymakers must take steps to strengthen the workforce:

- Broaden eligible mental health professionals for Medicare reimbursement to provide full costs for all mental health workers located in MHPSAs and licensed or credentialed by their state or tribe
- Expand of the Medicare Graduate Medical Education (GME) program to include residency caps specific to the behavioral health workforce with an allocation specific to rural areas to allow individuals to train and remain in rural areas
- Expand scholarship and loan repayment programs to encourage rural mental health practice

Increase integration, coordination, and access to care:

- Improve the knowledge base of primary care providers by integrating treatment of behavioral health into primary care
- Promote the delivery of mental health services by federally qualified health centers, rural health clinics, critical access hospitals, and rural hospitals
- Create targeted grant programs to allow non-traditional health care providers to supply mental health care services in rural communities, including schools, community centers, senior citizen facilities, and libraries

Further the use of telehealth:

- Ensure all rural providers are able to provide mental health services via telehealth, particularly CAHs. NRHA supports congressional action to extend mental health care reimbursement beyond the duration of the public health emergency (PHE) and asks for these flexibilities to be made permanent.
- Because of the lack of broadband connectivity in rural and frontier regions, Congress must continue to allow the utilization of audio-only telehealth services beyond the duration of the PHE
- Develop policies that address cross-state professional licensing issues for mental health

Recommended Action

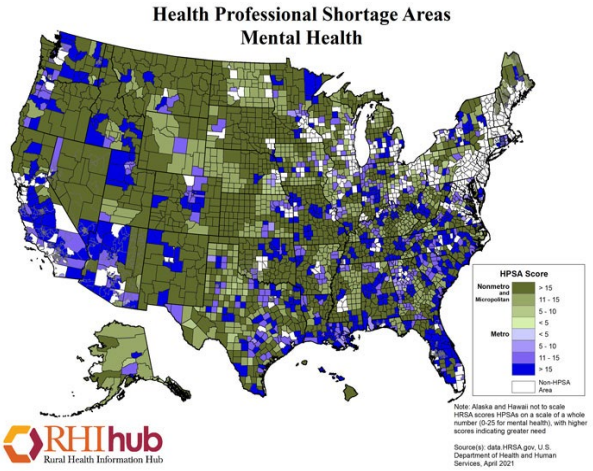
Support S. 828 Mental Health Access Improvement Act to expand coverage of providers under Medicare.
Support S. 165 Stopping the Mental Health Pandemic Act to award grants to support behavioral health treatment and services.

Overview

Throughout the COVID-19 pandemic, other epidemics have continued to grow in relative darkness, most notably mental health. The Substance Abuse and Mental Health Services Administration reports that during a given year one in five American adults experience mental illness.[ii] However, throughout the COVID-19 pandemic, 61% of rural adults say their mental health has been impacted.[iii] While rates of mental illness, anxiety, and depression are similar in rural areas compared to urban, there is a higher risk of suicide in rural areas, with nearly twice as many suicides in the most rural counties compared to urban. In rural communities, the suicide rate is between 18.1 and 20.1 per 100,000 residents, whereas in urban communities the rate is between 11.2 and 12.6 per 100,000.[iv] There are also variations within some rural subpopulations and communities in rates of depression, suicidality, disease burden, and mental distress, including women, low-income children, veterans, non-Hispanic Blacks, and American Indian/Alaska Natives.[v]

Barriers to Mental Health Access

Deficits in rural mental health care availability, accessibility, affordability, and acceptability all must be addressed when building a comprehensive policy framework around rural behavioral health reform.[vi]



Availability and accessibility are the primary barriers rural communities face regarding mental health care. As of March 31, 2021, 122 million Americans lived in a mental health professional shortage area (MHPSA), with 3,370 MHPSAs in rural areas. While rural America experiences higher prevalence of suicide, it also has the most significant MHPSAs. In Wyoming, 96.4% of the state is categorized as a MHPSA compared to just 0.4% in New Jersey.[vii] The lack of a mental health workforce in rural communities has resulted in rural residents being disproportionately represented in mental health deserts. As a result, rural residents often have to travel further to access services.[viii] Primary care providers offer 60% of behavioral health care in rural America and may lack the training and experience to handle serious behavioral health issues.[ix] Even as telehealth has expanded throughout the COVID-19 pandemic and federal legislation has allowed for mental health care to be provided via telehealth, rural residents still don't have the same access to broadband as their urban counterparts.[x]

Acceptability and stigma around mental health care continues to plague rural patients and limit access to services. Research suggests higher rates of mental health stigma in rural areas, which can inhibit help-seeking behavior.[xi] More than 80% of rural adults report they are most likely to trust their primary care doctor for information on mental health. Fueling stigma is the lack of privacy in rural communities. Often individuals feel more reluctant to seek treatment when anonymity is at risk.[xii]

Affordability is another large barrier associated with accessing care. Rural residents are more likely to be uninsured and underinsured for health care services in general.[xiii] When insured, rural Americans face higher coinsurance for mental health care than their urban counterparts. In rural communities, there is also a higher prevalence of insufficient coverage, resulting in higher out-of-pocket costs and decreasing service retention.[xiv]

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[v] https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf
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[ix] Wodarski JS. The Integrated Behavioral Health Service Deliver System Model. *Social Work in Public Health.* 2014; 29(4).
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